



# Questionnaire on visual height intolerance

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: f ☐ m ☐

Question	Variable		
<b>1. Have you already experienced visual height intolerance (distressing instability when standing or moving) while looking from a height?</b>	V1	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Continue to fill out the rest of the questionnaire only if you answered "yes".		 Continue	 Finished
<b>2. How strong do you estimate your visual height intolerance is?</b>	V2	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not strong Somewhat strong Moderately strong Quite strong Very strong
<b>3. How much do you feel it interferes with sports?</b>	V3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not at all A little Moderately Quite a lot Very much
<b>4. How much do you feel that visual height intolerance limits your activities in general, i.e. in everyday life?</b>	V4	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Not at all A little Moderately Quite a lot Very much

## Initial questionnaire on visual height intolerance with 16 questions

5. How much do you feel it reduces your quality of life?	V5	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Not at all A little Moderately Quite a lot Very much				
6. Visual height intolerance is induced by my... <i>(First 12 Codes Randomised)</i>	V6_1	Standing on or climbing up a tower	Not at all 1 <input type="checkbox"/>	A little 2 <input type="checkbox"/>	Moderately 3 <input type="checkbox"/>	Quite a lot 4 <input type="checkbox"/>	Very much 5 <input type="checkbox"/>
	V6_2	Standing on or walking over a bridge	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_3	Standing on or walking up steps	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_4	Standing on or climbing up a ladder	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_5	Standing on or walking on a balcony	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_6	Looking out of a window	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_7	Standing or walking on a scaffolding	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_8	Standing or walking on a roof	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_9	Riding on a carousel or a Ferris wheel	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_10	Riding in a ski lift or gondola	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_11	Wandering/ mountain climbing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
	V6_12	Rock climbing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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	V6_13	Other situations	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
	V6_13Ao	Examples	_____
7. I have visual height intolerance when exposed to heights	pV7	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	... occasionally ... often/frequently ... always
8. Now I have visual height intolerance that is...	V8	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	... less strong than before ... just as strong as before ... stronger than before
9 I have/had visual height intolerance for longer than 6 months.	V9	1 <input type="checkbox"/> 2 <input type="checkbox"/>	No Yes
<b>10A. What <u>bodily</u> symptoms do you feel when exposed to heights? (Multiple answers possible)</b>  <i>(1 -5 Random)</i>  <i>0 = nicht genannt</i> <i>1 = genannt</i>	pV101_1	<input type="checkbox"/>	Trembling
	pV101_2	<input type="checkbox"/>	Palpitations
	pV101_3	<input type="checkbox"/>	Inner agitation
	pV101_4	<input type="checkbox"/>	Sweating
	pV101_5	<input type="checkbox"/>	Moist hands
	pV101_7	<input type="checkbox"/>	None of the above
	pV101_9	<input type="checkbox"/>	Don't know, no response
10B. Do you feel very strong fear when exposed to heights?	pV102	1 <input type="checkbox"/> 2 <input type="checkbox"/>	Yes No
10C. Do you feel any other symptoms during visual height intolerance?	pV103	1 <input type="checkbox"/> 2 <input type="checkbox"/>	Yes No
<i>Filter: (only if answered "yes" to 10C)</i>  <b>10D. What additional symptoms do you feel when experiencing visual height intolerance? (Multiple answers possible)</b>  <i>(First 10 Codes Randomised)</i>  <i>0 = not named</i> <i>1 = named</i>	pV104_1	<input type="checkbox"/>	Giddiness
	pV104_2	<input type="checkbox"/>	Postural (to-and-fro) dizziness
	pV104_3	<input type="checkbox"/>	Weakness in the knees
	pV104_4	<input type="checkbox"/>	Instability of stance and gait
	pV104_5	<input type="checkbox"/>	Malaise/queasy feeling in the stomach region
	pV104_6	<input type="checkbox"/>	Oppression

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	pV104_7	<input type="checkbox"/>	Fearfulness
	pV104_8	<input type="checkbox"/>	Mental image of falling
	pV104_9	<input type="checkbox"/>	Gait disorder
	pV104_10	<input type="checkbox"/>	Thinking blocked
	pV104_11	<input type="checkbox"/>	Other, for example
	pV104_96	<input type="checkbox"/>	None of the above
	pV104_99	<input type="checkbox"/>	Don't know, no response
<p><b><i>The following questions have to do with your general state of health. Your answers will allow us to understand how you feel and how you cope in your daily routine.</i></b></p>			
11. How would you describe your general state of health?	V11	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Excellent Very good Good Not so good Bad
<p><b><i>The following questions are about how you cope with visual height intolerance.</i></b></p>			
12. I try in advance to avoid exposure to heights.	V12	1 <input type="checkbox"/> 2 <input type="checkbox"/>	No Yes
13. I quit as fast as possible all situations of acute exposure to heights.	V13	1 <input type="checkbox"/> 2 <input type="checkbox"/>	No Yes
14. I intentionally expose myself to heights.	V14	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	No Occasionally Yes
15. Have you already finished a training program to cope with visual height intolerance?  <i>Filter: Only when 15 was No</i>	V15	1 <input type="checkbox"/> 2 <input type="checkbox"/>	Yes No
16. Are you planning on training to cope with visual height intolerance?	pV16	1 <input type="checkbox"/> 2 <input type="checkbox"/>	Yes No